

BLUE WATER DIAGNOSTICS - REFERRAL FORM

704 Mara Street, Point Edward, Ont. N7V 1X4 519-336-1555 FAX: 519-336-2193

REFERRING PHYSICIAN: _____

PATIENT DEMOGRAPHICS:

NAME: _____ M _____ F _____
(First) (Last)

DOB: _____ ADDRESS: _____
(month/day/year)

OHIP NUMBER: _____ VERSION CODE _____

TELEPHONE NUMBER(S): HOME: _____ WORK: _____
CELL: _____

MEDICAL INFORMATION:

DOES YOUR PATIENT USE ANY OF THE FOLLOWING MEDICATIONS: (please tick)

COUMADIN (warfarin) _____ ASPIRIN _____ PLAVIX _____ TICLID _____

OTHER MEDICATIONS: (please list)

DOES YOUR PATIENT HAVE ANY HISTORY OF:

ANGINA / MI	YES _____	NO _____	DIABETES	YES _____	NO _____
ASTHMA	YES _____	NO _____	TIA/CVA	YES _____	NO _____
			BLEEDING DISORDER	YES _____	NO _____

ALLERGIES: (please list) _____

(If your patient normally receives prophylactic antibiotics, e.g. for dental procedures, please note that current guidelines **do not** recommend the use of prophylactic antibiotics for gastroscopy and/or colonoscopy except in patients with complex congenital cardiac abnormalities or with mechanical heart valves. Such patients are better suited to a hospital setting.)

PRESENT COMPLAINT: _____

SERVICE REQUESTED: (please tick) **GASTROSCOPY** _____ **COLONOSCOPY** _____

GASTRIC BALLOONING _____ **(WEIGHT LOSS PROCEDURE)**

(Please note that the procedure(s) will be carried out at the time of consultation unless any contraindication exists.)

Signature of Referring Physician

Billing Number

PLEASE **FAX** TO BLUE WATER DIAGNOSTICS AT: **519-336-2193**

WE WILL CONTACT YOUR PATIENT DIRECTLY FOR APPOINTMENT DATE AND TIME

THANK YOU FOR YOUR REFERRAL